You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to EDS at the address below. Information that is typed in will not be saved in the form once the document is closed.

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )

Requesting Provider NPI # _____

Phone with Area Code _____

Name _____

Recipient Medicaid #_____

Name _____

Address _____

City/State/Zip _____

EPSDT Screening Date _____ DOB _____

Prescription Date CCYYMMDD _____

Rendering Provider NPI # _____

Phone with Area Code _____

Fax with Area Code _____

Name _____

Address _____

City/State/Zip _____

Ambulance Transport Code _____

Ambulance Transport Reason Code _____

DME Equipment: _____ New _____ Used

First Diagnosis _____._____ Second Diagnosis _____._____

Assignment/Service Code ____ Patient Condition ____ Prognosis Code ____

(01) Medical Care	(48) Hospital Inpatient Stay*	(75) Prosthetic Device
(02) Surgical	(54) LTC Waiver	(A7) Psychiatric-Inpatient*
(12) DME-Purchase	(56) Ground Transportation	(AC) Targeted Case Management
(18) DME-Rental	(57) Air Transportation	(AD) Occupational Therapy
(35) Dental Care	(69) Maternity	(AE) Physical Therapy
(42) Home Health Care	(72) Inhalation Therapy	(AF) Speech Therapy
(44) Home Health Visits	(74) Private Duty Nursing	(AL) Vision-Optometry

Line Item	DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____

_____

_____

_____

_____

_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____ Date _____

FORWARD TO: EDS, P.O. Box 244036 Montgomery, Alabama 36124-4032